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Educational Media Leaflet Increases Nurses' Knowledge about Nursing Documentation Audit

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Abstract

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Background: The nursing management process starts with planning, organizing, commanding/coordinating, and controlling. One part of the controlling function is the nursing documentation audit. Nursing documentation audit is a professional evaluation process on the quality of nursing services which have been carried out by the nursing and midwifery profession against patients, namely through patient medical records.
Objective: Nurses can implement nursing documentation audits at Ar-Raudah 1 room of Makassar Hajj Hospital.
Methods: This study used a case study method. This study implemented education through leaflet media to enhance nurses' knowledge in implementing nursing documentation audits. A total of 14 nurses participated in this study. Data collection was obtained from interviews, observations and questionnaires.
Results: The findings showed that the pre-test nurses' knowledge on P3 as many as 10 nurses (71.4%) answered correctly and as many as 4 nurses (28.6%) answered incorrectly. As for P7, 14 nurses (100%) answered incorrect. An increase in knowledge occurred during the post test, namely P3 (100%) and P7 (100%). After nursing implementation, namely education through leaflet media, it showed that nurses' knowledge increased in the application of nursing documentation audits.
Conclusion: Nurses at Ar-Raudah 1 room of Makassar Hajj Hospital show an increase knowledge about nursing documentation audits.

Keywords: Documentation audit; leaflet media; nurse knowledge

Introduction

There are several meanings of management, namely commanding, managing, executing, driving and managing (Dewi, I. K., & Mashar, 2019). Nursing management is one of the processes so that a work can be completed starting from planning, organizing, directing, and controlling. In this process, it is carried out to provide biological, psychological, social and spiritual services to a person comprehensively through a nursing process, both healthy and sick in achieving a set goal (Asmuji, 2014). A principle is needed in implementing nursing management, namely planning, effective time, decision-making, managing, compiling and changing. There are five stages of the nursing process starting from assessment, diagnosis, intervention, implementation, and evaluation (Mugianti, 2016).

The nursing management process starts from *planning*, *organizing*, *commanding/coordinating* and *controlling* (Setyawan & Supriyanto, 2019). Control is defined as a process of management which is very important. According to Henry Fayol, control is one of the processes where all things that are done are in accordance with the plan. Control is a management effort in achieving predetermined goals where continuous comparisons are made between plans and implementation (Seniwati, 2022).

An activity that is included in the control function is an audit of nursing documentation. According to PMK of the Republic of Indonesia Number 49 of 2013 says that the audit of nursing documentation is a professional evaluation process on the quality of nursing services which has been carried out by the nurse profession and midwives on patients, namely through the patient's medical records (Minister of Health of the Republic of Indonesia, 2013). Many audits are drafted without being guided by theory or not explicitly building on previous research so that to check a

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successful audit there is little progress. The heterogeneity of the context and variation at the audit level states that it is impossible in a location to use the same way for audits to work. Continuous socialization and planned guidance and carrying out a training activity in improving a nurse's competence related to nursing documentation audits (Hut-Mossel et al., 2021). Nursing has an obligation and responsibility to the community to develop the quality of care in order to improve patient safety and the efficiency of the health service system. This responsibility should be supported by comprehensive documentation audit practices. Nursing documentation audits provide an important indicator of the quality of care provided (Damanik et al., 2020). The implementation of documentation audits is important because it can find out whether there are deviations from existing standards, criteria, and norms (Brima et al., 2021).

In documenting nursing care, it is sometimes not of good quality and not in accordance with standard operational procedures. Research conducted by Nellisa et al., (2022) shows that the nursing assessment stage is 80% which means that the overall documentation is almost complete, the diagnosis stage is 100% incomplete, the intervention stage is 20% incomplete, the implementation is 30% incomplete and the evaluation is 90% incomplete. This is also in accordance with the research of Tasew et al., (2019), which is 47.8% in documenting incomplete nursing care. The researcher concluded that the implementation of documentation in the inpatient room was in the incomplete category. The results of the study vary from hospital to hospital related to the completeness of nursing documentation. The research from Saraswasta et al., (2020) shows that 50% of nursing documentation at Rumah Sakir X has been appropriate. Meanwhile, according to research by Ardenny & Idayanti (2017), 57.8% of nursing care documentation was obtained.

Based on the results of the audit of the documentation of 10 medical records at Ar-Raudah 1 room, there were still some that have not been completed since the client entered with pain complaints such as the initial assessment of pain was not filled in. There were three medical records whose diagnosis data was not in accordance with the assessment, and no one wrote down the risk diagnosis, only the actual diagnosis. Based on the results of direct interviews with nurses, it was found that almost all nurses had never received socialization or training regarding nursing documentation audits.

Methods

Study Design

The type of this study was a case study. This study included an assessment whose purpose was to find out the background, characteristics of diarrhea and investigate the case in depth and detail through observation and interview methods. Then determine the priority of problems to find out the cases that will be overcome first, as well as make a Planning of Action (POA) to overcome problems in the cases raised. After that, it is carried out to implement the Planning of Action (POA) that has been determined and evaluate the results of the actions that have been given.

Samples/Participants

The samples in this study were nurses at Ar-Raudah 1 room of Haji Makassar Hospital totaling 14 nurses to find out the knowledge of nurses related to the implementation of nursing documentation audits. In this study, the inclusion criteria were nurses who have been given education from start to finish and the exclusion criteria were nurses who were on leave.

Instruments

The instrument used in this case study was the standard documentation audit instrument for nursing care in finding out more about nurses' knowledge in the implementation of nursing documentation audits in hospitals. In addition, education in the form of leaflets was provided to assess the knowledge of pre-posttest in the implementation of documentation audits. The research instrument used a list of 19 questions consisting of 5 assessed aspects. First, the assessment aspect consists of 4 questions. Second, the diagnostic aspect consists of 3 questions. Third, the planning aspect consists of 6 questions. Fourth, the implementation aspect consists of 4 questions. Fifth, the evaluation aspect consists of 2 questions.

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Interventions
Education through leaflet media to increase nurses' knowledge about nursing documentation audits at Ar-Raudah 1 room of Haji Makassar Hospital.

Data Collection
This case study was carried out on May 13 to June 1, 2024.

Results

Table 1 showed the results of the pre-test that had been carried out before being given education through leaflet media on the knowledge of nurses, which consisted of 19 statements in P3 as many as 10 people (71.4%) answered correctly and as many as 4 people (28.6%) answered incorrectly. Meanwhile, in P7, as many as 14 people (100%) answered incorrectly. After being educated through leaflet media on nurses' knowledge, the results of the post test, namely from 19 statements on the nursing documentation audit knowledge instrument, as many as 14 people (100%) answered correctly. Therefore, it can be concluded that there is an increase in nurses' knowledge about providing education through leaflet media.

Table 1. Pre-test and Post-test of Nurses Knowledge

Statement	Pre-test				Post-test			
	Correct		Incorrect		Correct		Incorrect	
	n	f	n	f	n	f	n	f
1	14	100%	0	0%	14	100%	0	0%
2	14	100%	0	0%	14	100%	0	0%
3	10	71,4%	4	28,6%	14	100%	0	0%
4	14	100%	0	0%	14	100%	0	0%
5	14	100%	0	0%	14	100%	0	0%
6	14	100%	0	0%	14	100%	0	0%
7	0	0%	14	100%	14	100%	0	0%
8	14	100%	0	0%	14	100%	0	0%
9	14	100%	0	0%	14	100%	0	0%
10	14	100%	0	0%	14	100%	0	0%
11	14	100%	0	0%	14	100%	0	0%
12	14	100%	0	0%	14	100%	0	0%
13	14	100%	0	0%	14	100%	0	0%
14	14	100%	0	0%	14	100%	0	0%
15	14	100%	0	0%	14	100%	0	0%
16	14	100%	0	0%	14	100%	0	0%
17	14	100%	0	0%	14	100%	0	0%
18	14	100%	0	0%	14	100%	0	0%
19	14	100%	0	0%	14	100%	0	0%

Source: Primary Data, 2024

Discussion

Analysis of Nursing Assessment
The nursing assessment has been carried out at Ar-Raudah 1 room of Haji Makassar Hospital for three weeks by carrying out an initial survey, collecting observation data and interviews. The results of the assessment obtained by direct interviews with nurses obtained data that almost all nurses have never received socialization regarding nursing documentation audits. Based on the observation results, it was found that the results of the documentation audit of 10 medical records in the aspect of the assessment there were 8 (80%) medical records where the assessment was still not completed since the client entered, such as the initial assessment of pain was not filled in patients who experienced pain. This is related to the research by Nellisa et al., (2022) who suggested that of the 10 medical records observed, the results of the documentation study in the inpatient room at the

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assessment stage were 8 unfilled medical records (80%) and there were 2 unfilled medical records (20%). This is also related to the research by Artika (2016) which said that at the assessment stage in conducting an assessment of the initial patient data carried out by nurses is still in the low category (96.3%). However, the results of the study are not related to the research by Irawan (2016) who found that at the assessment stage in documenting nursing care is still in the good category (83.3%) and Firadika (2020) also said that at the stage of reviewing nursing care documentation is still in the complete category (76.3%).

In the diagnostic aspect, there are 3 (30%) medical records whose diagnosis data is not in accordance with the assessment and of 10 (100%) medical records no one writes the risk diagnosis only the actual diagnosis. This is related to the research by Nellisa et al., (2022) which found that of the 10 medical records in the inpatient room at the nursing diagnosis stage, all of them have not been filled in completely (100%). Of the 10 medical records observed, at the diagnosis stage there were some nurses who did not formulate a risk nursing diagnosis. This is also related to the research by Nurjannah (2013) which suggested that at the stage of nursing diagnosis, most of the completeness of the documentation as many as 67 documents (70.5%) are still included in the incomplete category. However, this is not related to the research of Maurissa et al., (2020) who said that at the nursing diagnosis stage, the implementation of nursing care documentation was in the good category (94.33%) and the research conducted by Siswanto et al., (2013) which said that at the nursing diagnosis stage, nurses carried out nursing care documentation in the complete category (100%).

The results of observations at Ar-Raudah 1 room related to nursing care documentation from 10 medical records were filled in incompletely (100%) because most nurses were not optimal in carrying out nursing care documentation at the assessment and nursing diagnosis stages. According to Berman et al., (2016) documentation is a patient record that is used as an official and legitimate communication tool, if a problem occurs, it can be used as a legal basis, planning patient services and assessments for health institutions. Documentation is very important because all nursing care received by patients requires records and reports that if something goes wrong with the patient, it can be used as a responsibility and liability. According to Tasew et al., (2019) who said that most nurses at Tigray hospital do not do nursing care documentation because of limited time in recording documentation, unavailability of documentation sheets to write and no SPO from the hospital. According to the researcher's assumption, the nurses in the Ar-Raudah 1 room did not complete the nursing documentation audit because of the difficulty of nurses managing the time between carrying out the documentation that had to be filled in at the BRM as well as on the computer and carrying out nursing care actions.

Nursing Problem Analysis

The problem found in the assessment at Ar-Raudah 1 room was the lack of knowledge of nurses in the implementation of nursing documentation audits. According to Juniarti et al., (2020), nursing documentation is one of the last management functions, namely control.

Analysis of Nursing Interventions

Based on the results of the assessment at Ar-Raudah 1 room, it was found that there was a problem of lack of nurse knowledge in the implementation of nursing documentation audits, so that the intervention that would be carried out was education through the media leaflet of nurses' knowledge in the implementation of nursing documentation audits. Leaflet media is a sheet that can be folded as a form of conveying information and health messages in the form of images, sentences and combinations that are very good to use compared to other media. Using leaflet media can improve health promotion through an education obtained by the five senses based on the results of observation and knowledge will be formed from the response or effect of a five-sense process through stimulus in leaflet media (Gani et al., 2014). According to the researcher's assumption, nurses were encouraged to participate in the development of information technology to carry out a function and task in nursing management properly.

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Nursing Implementation Analysis

Education about nursing documentation audits using leaflet media has been implemented to overcome the lack of nurses' knowledge in the implementation of nursing documentation audits. This means aimed to provide increased knowledge for nurses related to the implementation of nursing documentation audits so that serving clients becomes more optimal. Before being given education, a pre-test questionnaire was distributed to assess the level of knowledge of nurses. After the education, a post test questionnaire containing the same statement was distributed to assess the level of knowledge of nurses after the material was given.

Of the 14 nurses at Ar-Raudah 1 room, as many as 9 (64.2%) nurses had never received socialization regarding the audit of nursing documentation. Most nurses still did not understand about nursing documentation audits, so changes were needed, namely education which was provided through leaflet media so that nurses' knowledge increases related to nursing documentation audits. This is in accordance with research by Arimbawa (2022) which found that using leaflets is one way that can be done in increasing nurse knowledge. The words of Allah SWT in QS. Al-Mujadalah/58:11.

يٰٓاَيُّهَا الَّذِيْنَ اٰمَنُوْٓ ا اِذَ ا قِيْلَ لَكُمْ تَفَسَّحُوْا فِى الْمَجٰلِسِ فَافْسَحُوْا يَفْسَحِ اللّٰهُ لَكُمْۚ وَاِذَا قِيْلَ انْشُزُوْا فَانْشُزُوْا يَرْفَعِ اللّٰهُ الَّذِيْنَ اٰمَنُوْا مِنْكُمْۙ وَالَّذِيْنَ اُوْتُوا الْعِلْمَ دَرَجٰتٍۗ وَاللّٰهُ بِمَا تَعْمَلُوْنَ خَبِيْرٌ

Translation:
"O you who believe, when it is said to you, "Give space in the assemblies," be open, and Allah will surely give you space. When it is said, "Stand up," stand up. Allah will undoubtedly raise up those who believe among you and those who are given some degree of knowledge. Allah is very careful about what you do" (QS. Al-Mujadalah/58:11).

The above paragraph explains the advantages of having an assembly in this case carrying out education related to nurses' knowledge in the implementation of nursing documentation audits. The prohibition of whispering revealed in the previous verse is a firm behavior to build good relations between others (Al-Mahalli, I. J., & As-Suyuti, 2010).

Allah SWT said, "O you who believe, if it is said to you", from whoever is spacious, that is, try earnestly even though you have to force yourself to give others a place in the assembly, whether it is in the form of a seat or not. If you are asked to do so, then make room for that person voluntarily (Al-Mahalli, I. J., & As-Suyuti, 2010).

Nursing Evaluation Analysis

The results of the evaluation were obtained from the knowledge of pre-test nurses in P3 as many as 10 people (71.4%) answered correctly and as many as 4 people (28.6%) answered incorrectly. Meanwhile, in P7, as many as 14 people (100%) answered incorrectly. In P7, it is about "Nurses formulate risk diagnoses". The increase in knowledge occurred during the post test, namely P3 (100%) and P7 (100%). This is in line with the research of Murtiningsih et al., (2021) at Pasar Rebo Hospital Jakarta which stated that the knowledge of respondents from the pre-test was obtained in the categories of poor (85.7%), adequate (14.3%) and at the time of the post-test the knowledge of nurses increased with the categories of good (71.4%) and sufficient (28.6%).

After being educated, based on the results of the documentation audit of 30 medical records carried out by researchers in the diagnostic aspect, there were still 3 (10%) medical records that do not write a risk diagnosis. Based on the results of an interview with one of the nurses at Ar-Raudah 1 room who said that she often forgot to complete the documents in the medical record was affected by the workload and had to fill in the BRM and computer. This is related to the research of Ardenny & Idayanti (2017) showing that low individual motivation is seen when completing nursing care in the inpatient room. This can also be due to a lot of workload factors so that individuals easily forget to complete the documents in nursing care.

Limitations obtained during the implementation of this case study, including: 1) In carrying out this study, all interventions could not be carried out simultaneously on all nurses due to differences in nurse service schedules.; 2) Educational intervention through nursing management leaflet media in the hospital service order at Ar-Raudah 1 room of Haji Makassar Hospital was not the only

intervention carried out to increase nurses' knowledge about the implementation of documentation audits, but still required further intervention.

Conclusion

The provision of education using leaflet media to nurses at Ar-Raudah 1 room of Haji Makassar Hospital shows a change in nurses' knowledge. The results of the evaluation after the nursing documentation audit education were carried out is that there is an increase in nurses' knowledge at Ar-Raudah 1 room of Makassar Hajj Hospital about nursing documentation audits.

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